State Police Officers Council

Health Benefit Comparison

Effective July 1, 2008

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate you will receive after you enroll and the enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

Plan Provisions	Alliance Select
Lifetime Benefits Maximum – The maximum amount each covered family member is eligible to receive under this plan for covered services in his or her lifetime.	Unlimited
Lifetime Maximum on Infertility Services	$15,000; Coinsurance does not apply to OPM.
Out-of-Pocket Expenses – The amount you pay for certain covered services. There are two types of out-of-pocket expenses: 1) Deductible - a fixed amount you pay for certain services before Wellmark makes benefit payments. Coinsurance - a fixed percentage you pay for certain services.	See below for your specific out-of-pocket amounts.
Out-of-Pocket Maximum (OPM) – The maximum amount you pay for covered services in a calendar year. Once your OPM is satisfied, most services are covered in full through the end of the calendar year.	Single $750 Family $1,500

Health Plan Basics	Alliance Select
Benefit Period Deductible - Applies to **ALL** Services except Well Child Care	Single $250 Family $500
Coverage for Care Provided Outside of Iowa	BlueCard® PPO Program benefits apply.
Precertification	Inpatient admission, home health and hospice Out-of-Network - Member's responsibility to precertify 50% penalty for failure to precertify. In-Network - Select provider performs
Waiting Period	None except for late enrollees, then 18 months.
Dependent Child Age Limit	Unmarried dependent to age 19 unless a full time student, then unlimited

Source: DAS Benefits Team
05/08/08

When You Receive These Covered Services:	You Pay:	
	Alliance Select	
	In-Network (Select Provider)	Out-of-Network (Non-Select Provider)
Office Visit Service	10% coinsurance after deductible	20% coinsurance after deductible
Specific Preventive Services – Includes one routine physical and related services (x-rays and lab work) per benefit period; mammogram; well-child care to age 7 including immunizations.	10% coinsurance after deductible	20% coinsurance after deductible
Immunizations	Not covered except for well child to age 7.	
Inpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible
Inpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible
Emergency Services **Physician's office** **Emergency room -** Applies after OPM is met; waived if admitted	10% coinsurance after deductible $100 copayment. 10% coinsurance after deductible	20% coinsurance after deductible $100 copayment. 10% coinsurance* after deductible
Accident Care	10% coinsurance after deductible	20% coinsurance after deductible
X-Ray & Lab **Inpatient** **Outpatient** **Office**	 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Chiropractic Care	10% coinsurance after deductible	20% coinsurance after deductible
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible

*** Processed at in-network level if true emergency.**

When You Receive These Covered Services:	You Pay:	
	Alliance Select	
	In-Network (Select Provider)	Out-of-Network (Non-Select Provider)
Routine Eye Exam - One per member per year	10% coinsurance after deductible	20% coinsurance after deductible
Maternity		
Inpatient	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Office	10% coinsurance after deductible	20% coinsurance after deductible
Mental Health/Chemical Dependency	**Inpatient:** 10% coinsurance after deductible **Precertification is required** **Annual limit of 30 inpatient days per family member** **Outpatient:** 10% coinsurance after deductible **Annual limit of 52 outpatient/office visits per family member** **Office services:** 10% coinsurance after deductible **Annual limit of 52 outpatient/office visits per family member**	**Inpatient:** 20% coinsurance after deductible **Precertification is required** **Annual limit of 30 inpatient days per family member** **Outpatient:** 20% coinsurance after deductible **Annual limit of 52 outpatient/office visits per family member** **Office services:** 20% coinsurance after deductible **Annual limit of 52 outpatient/office visits per family member**
Prescription Drugs	10% coinsurance after deductible	